MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
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AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
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ALAN R. NELSON, M.D.
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CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

DR. WILENSKY: Julian?

MR. PETTENGILL: Good morning. We're here to discuss first, chapter one, the overview chapter for the report. We sent you a draft that was in several pieces, yet to be knit together, and also missing a summary of our conclusions or review, which we will put in early on in the chapter so that we catch everyone's attention right up front.

This morning, I'd like to start with what are the objectives of the chapter. We really wanted to provide background and context for the rest of the chapters in the report and to provide the overall sense of your judgment about what the situation is in rural America, the extent to which there is a problem, the extent to which that problem is related to Medicare and Medicare's policies, and also some consideration of to what extent other policies outside of Medicare might be appropriate to pursue, without being specific about which ones because you haven't discussed that much.

We begin with how rural areas are defined, then talk a little bit about what rural health care looks like according to the literature, and the factors that affect demand and supply in rural markets, and then we talk about regional differences in market conditions across the country, that is the diversity of market conditions, the supply responses in each area among providers, and patterns of care, which is the use rate part of the analysis.

And then finally, a section that was not included in the draft but will be written, some discussion of the implications for Medicare and other policies.

I wanted to show you some information that we have pulled together with the help of some people at the Rural Research Center at the University of North Carolina.

We have two principal definitions of rural and rural areas in this country at the moment, that are widely in use. One is the census definition and the other is the set of definitions developed by the Office of Management and Budget. Census defines rural -- in fact, they both define rural as in the negative, that is not urban. Census does it

by saying that people and buildings and territory are urban if they're included in an urbanized area, which is defined by population size and density. Or they are in a place with 2,500 or more people outside of an urbanized area.

I would personally not like to be in charge of operationalizing that definition myself.

But in any event, OMB takes the census data and defines metropolitan and non-metropolitan, which we translate as urban and rural, based on the characteristics of the county, population size, relationship to a city, population density, commuting patterns. The idea there is that a metropolitan area is one that is social and economically integrated with a city. And anything beyond the central core county and the outlying suburban counties that are related is non-metropolitan.

Depending on which definition you use, the rural population is either 25 percent under the census definition of the population, or it's 20 percent under the OMB definitions. The reason that you get such a big difference is that a lot of rural, so-called non-metropolitan counties,

have in fact urban areas within them. And conversely, a lot of metropolitan counties have rural areas within them, areas that are not urbanized. That's what accounts for the difference.

This map gives you an idea of the overlap. The very dark areas are the urbanized areas. The gray areas are the counties included in the MSAs. You can see that the very dark areas do not fill up more than a small fraction of the space in quite a few so-called metropolitan counties. You don't see very many dark spots in the white areas, which are non-metropolitan counties, but there are some out there.

Because metropolitan and non-metropolitan just define two broad categories, they kind of leave you with the impression that rural is rural and urban is urban and they're both pretty homogeneous internally. To get at the diversity within them, various researchers -- beginning at the Department of Agriculture actually -- have defined alternative classifications of counties, one of which we use, the urban influence codes shown in the next overhead.

You saw this diagram at the last meeting. The UIC

codes are based on whether the county is included in a metropolitan area and, if so, what size metropolitan area, over or under 1 million population. And then for non-metropolitan counties, they're classified according to whether the county is adjacent to an urban area, what size urban area it's adjacent to, and what is the size of the largest town in the county.

Now for many of the analyses that we have done in this report, we use the UIC categories but we collapse them. We have collapsed them in somewhat different ways in different places. The main reason for collapsing them in most cases is that we have a limited sample of information. Consequently, we can't really look reliably at some of the counties.

In others we collapse them because of the relationship, there really is no difference. For example, it turns out that adjacency, in many instances, is much less important than the size of the largest town. That's what makes a difference in the adjacency.

So in many cases, we collapsed one and two so we

show a single category for urban. We collapsed three and five and four and six, which gives us categories based on town size. We end up with six categories.

I put in the paper the rural/urban continuum codes. That's an equally interesting way of classifying rural and urban areas but it's not the one we chose to use for our purpose. It is in the report, but I don't see the need to discuss it.

For a lot of the work for this chapter, we wanted to be able to characterize the market conditions that exist in different rural areas and we found that the best way to do that, since the hospital is essentially the center of the health care delivery system in rural areas, we decided to use hospital markets as the unit of analysis.

We defined them as indicated on the overhead, or I should say our friends at the Rural Health Research Policy Analysis Center defined them using patient origin data from Medicare to build a hospital-specific market for each hospital that includes all of the zip codes that together account for 80 percent of the discharges for that hospital.

And then we took zip code data from Claritus Corporation, which is largely census data, and calculated means and medians and what not of population characteristics for the zip codes collected in each hospital market.

The next overhead shows the geographic distribution of those markets. Probably the xerox in front of you isn't wonderful. I know mine isn't.

I think the central fact that sort of leaps out at you, just from looking at this map, is that there are enormous differences in hospital density across the country. This is no great surprise. There are many more hospitals much more tightly packed together in the East than in the West.

DR. NEWHOUSE: Julian, is there any difference between the marks that cross and the marks that go this way and the marks that go that way?

MR. PETTENGILL: There are two levels of crosses here. The lighter level is one hospital. The darker one is a pair that are right together.

DR. WAKEFIELD: So the X is a pair?

DR. ROWE: The X's are rural hospitals.

DR. REISCHAUER: There's a back slash and a forward slash.

MR. PETTENGILL: I think that's more a function of the xerox than it is the actual map. When you see the map published -- we will perhaps play around with alternative symbols that might show up more clearly.

Basically, there is a difference. The lighter gray ones represent a single hospital, the darker ones represent a pair that is so close together that you can't print a separate symbol.

MR. SMITH: The direction of the slashes doesn't tell us anything?

MR. PETTENGILL: No, nothing. Ignore that.

MS. RAPHAEL: I've been trying to understand the issue of distance and the 35 miles, which you will come to later. But when have earlier that something is adjacent to an MSA, how is adjacent defined?

MR. PETTENGILL: Adjacent is in the context of the county. The county is adjacent to an MSA.

DR. REISCHAUER: Some of this is really amazing here, because if you go to Nevada and New Mexico here, and you look at somebody who is living in the far reaches of a metropolitan area, that's like the moon where they are. And yet we have them classified as metropolitan.

MR. PETTENGILL: Yes, that's true. Look at Riverside County or San Bernadino County or Duluth County.

DR. REISCHAUER: Right, they're all the way across the state.

MR. PETTENGILL: Same problem. You have one part of the county is dense, urban area and 100 miles away, in the same county, you have a completely rural area.

There is a feature of Medicare policy for the swing bed criteria where Medicare uses something, by law, called the Goldsmith Modification, which is an attempt to identify portions of urban metropolitan counties that are rural. Which is why, when you look at the data and you see that we have hospitals that have swing beds but they're located in metropolitan areas, and you scratch your head and you say why does that happen? How can that be?

Swing beds are supposed to be for rural hospitals. Well, this is how it happens. The criteria that Medicare uses, in fact, the Goldsmith Modification identifies such areas within metropolitan counties that are, in fact, rural.

MR. DeBUSK: Julian, can you overlay this with the wage index region?

MR. PETTENGILL: The wage index regions are metropolitan statistical areas, the grayed out areas on the map, and non-metropolitan collections of counties in each state. So all the counties that are not metropolitan in a state are aggregated together, and that's considered to be the rural labor market area.

MR. DeBUSK: So that could be overlaid though, right?

MR. PETTENGILL: In effect they are. The light gray areas are the MSAs.

MR. DeBUSK: So this is the wage index areas within the state?

MR. PETTENGILL: Subject to one proviso. The boundaries of the MSAs have not been drawn in here. So

you've got some grayed out areas that represent multiple MSAs that happen to be adjacent to each other, they're not single markets. But if you would like to see a map like that, I'm sure we could include one in the hospital chapter where it would be more relevant.

MR. DeBUSK: I'd like to see it.

MR. HACKBARTH: Julian, I still don't understand the symbols on this map. The X's are rural hospitals, judging by the key. I don't understand what the single slashes are.

MR. PETTENGILL: Unfortunately, the xerox I have to look at is probably even worse than the one you have, so I'm not sure that I can --

MR. HACKBARTH: It doesn't look like it's xeroxing. These are clearly defined marks on the map.

MR. PETTENGILL: Actually these are all X's. It is the xeroxing. There is no difference. If it slants this way or it slants this way, it doesn't matter.

MR. HACKBARTH: These are all rural hospitals.

MR. PETTENGILL: They're all X's. I have seen the

original PDF map and they're X's. They will print in the document, in the report, much better than you see here. The problem here is that you can't xerox this kind of stuff very well.

I think we want to move on.

I included a section in the chapter that collects thoughts about rural health care from a variety of articles that I managed to squeeze time to read. And also characterized it as painting a fairly grim, gloomy picture, which I think it does. I mean, the literature says providing health care in rural areas is a struggle and you have multiple problems that you have to overcome.

The factors they've identified, in particular, are the size of the market, you have relatively few people so you have difficulty attracting professional staff; the population dynamics in many cases, the population is declining as portions of the working age population have moved out to seek employment elsewhere. You have an aging population in many areas. You have high levels of concentration of ethnic and racial groups in some areas that

represent a different set of problems, some of it cultural, differences in attitudes and that sort of thing. Some of it is sort of standing for other things, like the extent to which people have health insurance.

Physical isolation, we're always hearing about long distances that people have to go to receive care. Household income and unemployment. And obviously the proportion of the population who is uninsured. Many of the people who live and work in rural areas work for small employers who are much less likely to offer health insurance, so there's a smaller fraction of the population that is insured. Those that have insurance often have less coverage than you would find elsewhere.

We don't have, unfortunately, detailed geographic information on all of these variables. Health insurance, in particular, is a weakness. There just isn't a good source for that. But we do have information on the others.

When you look at the geographic patterns here I think what you see is that you have two main patterns, one in the West and one in the South and East. You also have

some differences along the Canadian border, where you have kind of a combination of the two sets of factors.

In the West the main factors operating are small population size, physical isolation, and declining population and an aging population. In the South it's a different constellation. It's relatively low household income and relatively high unemployment and high concentration of racial and ethnic minorities.

The next table shows some of that information, contrasting the East and the West. We did it for all markets in the East and the West. By the way, East here is defined as the five census divisions that all have New England, Middle Atlantic or East in their name. The West is the four census divisions on the western side of the country, which is Northwest, North Central, South Central, Mountain and Pacific.

The differences are not so striking when you look at all of the markets, but when you go down to the bottom quartile by population size of the market, that's the small group on the table, then I think the differences really

become quite striking regarding the likelihood that you have declining population, that you're isolated.

Isolated, by the way, means that you don't have another acute care hospital within 25 miles, which is not a terrifically restrictive definition, but if you do 35 miles the pattern looks very similar geographically.

DR. ROWE: Julian, can I suggest, given that we have a tremendous volume of material and some of these chapters are very long and detailed, a tremendous number of things to do, that maybe this analysis or any subsequent subanalyses about this, might be dispatched. I think it's bad enough we've got rural versus urban. Now we're going to have West versus East. It just lines up another way that people can fight about something but really doesn't add anything to the questions about Medicare policy in terms of rural versus urban, I don't think.

MR. PETTENGILL: I think what it adds is that neither East or West nor rural versus urban is really the issue. The issue is what are the market conditions? What are the problems you face? And they're different in

different places. The obvious implication is that the policy answer, to the extent there is one, is going to be different in different places. There's no one answer.

DR. ROWE: I certainly accept that, but I wouldn't want the data presented in such a way so it looks like the East is being disadvantaged compared to the West or vice versa, because it would just line the Congress and the Senate up on the East versus the West, as opposed to rural versus urban. Or maybe the next slide is North versus South, I don't know.

MR. PETTENGILL: Actually I think the maps do a much better job of saying you have -- if you go to the next map, for example, this is population size of the markets. This identifies the small markets.

By the way, small here means that the total population of the market area is less than 11,200 people. That's what the quartile definition is, 11,200 people in the market. That's not very many people.

And what this map says is that if you just look at small population you've got markets scattered -- now they're

concentrated heavily in the Midwest and the Northwest, but there are markets scattered all over the country that have very small populations.

DR. NEWHOUSE: Julian, I wonder if this isn't apples and oranges, if I understand this right. If you've got a 20-bed hospital and you go through the zip codes that account for 80 percent of its discharges, you're probably going to have the zip codes right around it and you're going to get a population figure like you got. Whereas if I have a 200-bed hospital, I'm going to inevitably have a lot more zip codes and more population, so it will look like a bigger market area.

MR. PETTENGILL: I have no doubt that's true. On the other hand, there's a very strong association between the degree to which the hospital is isolated the size of the market.

DR. NEWHOUSE: But it doesn't necessarily mean that it's isolated, just because it draws on a few zip codes that are nearby it and that fills it up.

MR. PETTENGILL: But we're not defining whether

it's isolated or not based on how many zip codes it has. It's based on the distance to the next nearest hospital.

DR. ROWE: But the point is, if you take the University of Iowa Medical Center, which is this huge, very elite place that is enormous and it must draw from five states around that area. That would like look like a huge market. They just happened to build a huge referral medical center there in the middle of Iowa. I don't see what that adds. I guess I'm sort of saying what Joe's saying.

DR. WAKEFIELD: Is part of what you're trying to demonstrate here -- and I might be misinterpreting, but I'm looking at the same map -- is the distance between or to other hospitals? Is that part of what you're trying to capture here?

MR. PETTENGILL: No, we have another map that shows the isolated hospitals. It's not the next one but the one after that. Those are hospitals where the next nearest hospital is at least 25 miles away.

We have a lot of hospitals in the Midwest -- if you go back to the small market base, it's true that big

hospitals would tend to draw from a much wider area and therefore have a bigger population. There's no question about that.

Many of these hospitals the market is defined essentially by one zip code because zip codes essentially align with the town and they're relatively small hospitals. That's their service area. And the population available to support them is the population that's right there.

DR. NEWHOUSE: But that's the issue. Suppose there's another hospital in a city that's 15 miles down the highway and they each draw from their own cities. If one hospital closed, the people 15 miles down the highway might come to the other hospital and it would grow.

There's an inherent problem defining market area. It's a classic problem and you're basically defining it off observed use. Conceptually, it could be better defined off of potential use but we don't observe that, so this is the best we can do.

DR. REISCHAUER: If you look at Kansas, it brings your point out. There's lots of small markets but not many

isolated ones.

MR. PETTENGILL: That's right.

DR. WILENSKY: There's nothing inconsistent with the kind of information you're presenting and making the point that I think is worthwhile, that Joe just made, which is that what we are looking at is observed market and, in principle, the market could be different particularly if there were different hospitals that were available.

I think that's a good point to make, so that when we're looking at these observed realities, we understand the context in which we ought to interpret these observations.

MR. PETTENGILL: I don't have any problem with that. In fact it comes in later when you start thinking about low volume adjustments and whether they should be restricted. It has an obvious application.

DR. WILENSKY: I think the point is worth making, but I don't think it takes away from the usefulness of how you've laid the information out.

MR. HACKBARTH: One of our challenges, one of our responsibilities is to try to simplify and make very

complicated situations understandable to policymakers. I'm worried about people getting lost in this succession of maps and data. I'm struck by the point that Bob pointed out, the seeming difference between the two maps when you look at Kansas.

I wonder if we ought to be trying to simplify this to bring home the basic points to our audience. This first map, with small market base, I don't find helpful in dealing with the policy problems. I think I understand what it means, but the critical issue -- given the earlier data you presented about what the problems are -- it's whether they're isolated or not, not whether they have a small market base.

MR. PETTENGILL: Actually that's not. You would think -- let's go to the map on isolation. You would look at that and you would say okay, these are isolated hospitals, these are the ones that have the small markets, and they would have low volume of demand, not just for Medicare but on the private side, as well. And that's what the problem is.

But in fact, there's not a close relationship between isolation and low volume. I have a table. If you go down further in your stack, it's the next table.

There is a relationship, but it's not a very strong relationship.

MR. HACKBARTH: But isn't the ultimate question, Julian, what happens if this hospital were to disappear? The fact that these isolated hospitals may not be low volume signifies that they're collecting people from a broad geographic area and that's a good thing.

Whereas, if we just have small market hospitals and they disappear and there's one down the road, is that a major public policy problem?

MR. PETTENGILL: It's certainly one of the questions. It's not the only one. I think part of the problem is that people tend to associate isolation with financial difficulty and there's not a strong association. Some isolated hospitals are, in fact, doing badly financially and are therefore at risk. And the population they serve is potentially at risk for that reason.

But in many cases, the isolated hospitals are not doing badly and they're not at risk. So it's a question of what sort of problem you want to solve.

DR. REISCHAUER: But I guess the question is what is the problem with small market base? One that is one town away and has equally small -- what is the problem? They might be in bad financial shape, but we don't have a potential access problem if one closes.

MR. PETTENGILL: That's why I tried to talk about clusters of problems because small population base by itself is one risk factor. It doesn't mean you have a problem. You have to put it together with a couple of others before you have a problem.

DR. ROWE: I think the issue is for me that many of the characteristics of some of these entities that are within the population we consider rural are terms that are laden. So when we use them, they sound bad. Like small market sounds bad. Isolated sounds bad.

It may not be bad. It may be that you have three hospitals in an area and they're all one-third full, that

two of them should close and then you have one left that's full and is doing well. And then you say oh my god, it's isolated.

My concern is that the way we're using these terms implies things that may not necessarily be there.

DR. NEWHOUSE: Julian, in the spirit of simplifying this, maybe you want to present the union of some of these characteristics rather than all these maps with each one singly.

MR. PETTENGILL: I'd have to try combinations like that and see what they look like.

DR. WILENSKY: I think the discussion, you might need to lead to that point and to talk about the issues initially as though these are all factors and to talk about why the factor may or may not be important, but to actually show pictorially the union which becomes now -- the intersection of these issues that becomes a problem.

So both in response to a comment I think Glenn made earlier, that we not overwhelm the reader with information, so you lead up to it. These are issues that

have been raised that may or may not sound as though they're problematic in terms of the term that is used, but the problem -- to the extent there is one -- appears at their intersection, here's what it looks like when you get small market or isolated and bring them together.

That might allow both the information initially, because it's hard to have the discussion on a two or three dimensional basis. But to approach that in that manner.

MR. PETTENGILL: I can certainly try that. What I had in mind with some of these things is to put four of these maps on a page, so that they're all right together. So if you had small market base and declining population and aging, and so on, and then the combination, you would see it all in one page.

DR. WILENSKY: The question is whether you could see that with that.

MR. PETTENGILL: I think the geographic patterns are strong enough and I've tried printing them four to a page, and I think it really does show more clearly,

actually, than looking one at a time.

DR. ROWE: Julian, it's clear you're going to do this, we're not going to talk you out of it.

[Laughter.]

MR. PETTENGILL: Jack, if it turns out that a map showing the combination is much more clear, I'll use it.

DR. NELSON: I'll have an easier time making a judgment about this after I've heard the rest of Julian's presentation.

MR. PETTENGILL: I think we can skip through some of this. The striking pattern in the South is low income and high unemployment. That map is a combination. That's South and East, and the pattern is pretty much where you would expect it to be.

The one thing I don't like about this is that this is nominal income. In other words, it doesn't reflect any adjustment for differences in the cost of living, and obviously that matters. But there isn't any good way to make an adjustment. We tried fiddling around with a couple of things, but it doesn't really change the pattern in any

event. I don't think there's anything really surprising here.

This suggests that there's a different problem in that area than you would see out west.

The consequence, a lot of times, of having a problem is that you end up with a provider that is operating at very low volume, and low volume is a major risk factor for poor financial performance. You'll see some of that later this afternoon in the data from the hospital chapter.

The analysis also seems to suggest that not all of these factors are all that important. The ones that seem to matter the most are small population, declining and aging population, which the intersection of them together is pretty strong, low income and high unemployment.

One of the consequences, as I said, is low volume if you have weak markets. But you can get to low volume a number of different ways. You can get there because the market base supporting your health care delivery infrastructure is weak. You can get there because you have a number of nearby competitors. Which reason got you there

matters from a policy point of view.

DR. NEWHOUSE: Are you going to distinguish those reasons in the charts?

MR. PETTENGILL: I don't know that I can distinguish them directly. I can show where markets are weak because of either small population that's declining and aging, or because you have low household incomes and high unemployment. It doesn't follow that all of those markets have low income. Only a fraction of them will. I could try the intersection of all of that.

DR. ROWE: Julian, I'm thinking of the Medicare+Choice program and I'm looking at these characteristics and I'm thinking that some of these might be factors that would lead to a failure of Medicare+Choice programs in an area because your population is older and therefore utilization is higher and there's a smaller population, not enough to handle the infrastructure, nearby competitors, et cetera.

It would be interesting if you had a composite of where these different major risk factors coexist, if you

also then sort of took a look at where the Medicare+Choice markets no longer exist, or no longer are problems, whether or not that is an overlay. That might be a proxy in some way for the market isn't there, if you know what I mean. It may be a useful kind of phantom measure where the market isn't doing well in something that's market based rather than demographically based.

MR. PETTENGILL: I don't know. I'd have to think about that one. I don't know if I would buy that, that the presence or absence of Medicare+Choice plans is a clear indicator that the market either is or isn't there. It is or isn't there for Medicare+Choice plans, but that's not the same as saying it is or isn't there for fee-for-service providers.

DR. ROWE: That's my question.

MR. PETTENGILL: I don't know. We have fee-for-service providers in a lot of places where there's no Medicare+Choice plan.

MR. SMITH: Julian, I was struck by what seemed to be an asymmetry in this list. Small population, declining

population, and low income seem to me part of what yields low volume. That low volume isn't independent of those first three, and that in reading the whole chapter it seems to me that -- to the extent that we can get a thread through the whole thing, that low volume appears to be it.

I'm struck by including it, as if low volume were an independent risk factor, rather than an artifact of the first three, which it seems to me your argument would lead us to.

MR. PETTENGILL: No, I'm much more inclined to treat it as an outcome, rather than as a risk factor. Yes. I agree.

MR. SMITH: It would seem to me it would help us think about what we're trying to fix here, back to Bob's question what's the problem. As I read the material, it strikes me that low volume is normally an outcome of the other risk factors, but it is often the problem that we ought to address policy to. I think it confuses that by treating it as a risk factor so coincident with what may be its causes rather than similarly structured risks.

MR. PETTENGILL: I'll have to think that through a little more and see how I can sort that out. I think you're right.

DR. STOWERS: Do you have a sense of the weighting? When we talk about low volume and then we talk about weak market base or nearby competitors, my sense is that the majority of it is their market base and that the free market and the ability of small communities to support unnecessary hospitals and so forth has already done a lot of the weeding out of the two hospitals sitting beside each other.

But yet when we list them directly beside each other, it looks like they're kind of equal. Do we have a sense of that? Because I think the nearby competitor thing out there is very small compared to the low volume and other things.

Another thing is when it comes to the survival of a hospital, low volume may not entirely be the problem. I think what you're getting to, it may be higher volume but uncompensated, coming with less insurance and all of the

other things. And that kind of has to show in there, too, a little bit.

MR. PETTENGILL: I don't know what to say about that. Quite a few of those low volume providers on that low volume map are right next to each other. I think it's been kind of a common -- I don't think it's a myth, I think it's a reality for years that communities exist, they have a hospital, it's a low volume hospital that's doing badly financially. They do whatever they have to do to keep it alive, because they regard it as absolutely essential to the survival of the community.

So I don't think the market has, in fact, driven out all of the facilities that probably can't be supported by a freely operating market.

DR. STOWERS: I guess the question here comes as what's right next to each other? I mean, if there's two hospitals within five miles or 10 miles or whatever. But if there's two communities 25 miles apart or 30, then -- I just don't have a sense of what percentage are where on this proximity.

MR. PETTENGILL: I think you can figure out how the distribution of the low volume providers breaks out by distance. I think you'll find that a number of low volume providers are not far away from the next nearest hospital.

I guess the only other thing I wanted to talk about here was the next table, which is on rural hospital diversification. There's another map in here just before that that associates low volume and reliance on long-term care.

There are quite a few facilities, and this is the combination -- and by the way, the labels are switched on that map. The light gray is, in fact, the low volume providers that have 50 percent or more of their patient days as long-term care. That's shown as black.

But the point here was that one of the things that you saw in the site visit out in Montana was that some of the small town low volume providers responded to their situation by providing a lot of long-term care. Essentially, they had a nursing facility, they had a rural health clinic, they had an outpatient department, and those

were the main sources of their revenues, not inpatient care, not swing bed care, and that sort of thing. That's how they stayed alive.

If you look at this table on diversification, this is by UIC code, you'll see a pretty clear pattern of what services hospitals tend to offer according to where they are. Swing beds goes way up as you go out into more and more rural communities. Separate skilled nursing facilities go down. The presence of a nursing facility that is not a swing bed unit or a SNF goes up. The fraction of facilities that are providing long-term care, any kind of long-term care, goes way up. But you don't get rehabilitation units and psychiatric units.

DR. ROWE: Julian, how do you reconcile these data with the statement that comes later in one of the other chapters that you make about the fact that the length of stay in these smaller isolated rural hospitals may be longer because they have less access to post-acute care facilities?

MR. PETTENGILL: I have difficulty reconciling that.

DR. ROWE: Those swing beds and SNF units and long-term care units associated with these hospitals that are very small...

MR. PETTENGILL: Have long lengths of stay. I think we have to recognize that the length of stay analysis that is there in the later chapter is really at the very beginning. It's a very preliminary analysis. I'm not suggesting that the numbers will change.

But I think if you look maybe at expected length of stay, given the DRG, you might see a somewhat different picture. Or it might well be the case that length of stay is simply higher than many of these places.

DR. ROWE: It may be something, but it might be worth, in the later chapter, including some of these data because there is that paragraph or two you have about the traditional reasons for this longer length of stay, blah, blah, blah, blah. Here, at least, are some data that are relevant.

MR. PETTENGILL: I think there's certainly an issue of consistency here that we will have to address.

DR. WAKEFIELD: Two quick questions. Julian, first on the map that's labeled low volume providers and reliance on long-term care, you use Montana as an example. Are all of the dots, the black and gray on that map, do they all refer to some type of long-term care being provided by a low volume provider except that one of them has greater than 50 percent long-term care days?

MR. PETTENGILL: The light gray is low volume provider.

DR. WAKEFIELD: No long term care?

MR. PETTENGILL: It just doesn't qualify as having more than half of its patient days as long-term care.

DR. WAKEFIELD: Then what's the other one?

MR. PETTENGILL: The other one is low volume providers that have more than half their patient days as long-term care.

DR. WAKEFIELD: So they all have long-term care?

MR. PETTENGILL: No, they're all low volume.

DR. WAKEFIELD: It's all low volume.

MR. PETTENGILL: And some of them rely heavily on

long-term care.

DR. WAKEFIELD: More heavily than the others?

MR. PETTENGILL: Much more heavily, yes.

DR. WAKEFIELD: And that's what you're drawing here.

DR. REISCHAUER: But there could be some with zero.

MR. PETTENGILL: That's correct, yes.

DR. WAKEFIELD: That's what I'm asking.

The second question is on the diversification by UIC, we don't have anything on home health probably?

MR. PETTENGILL: Actually we do. I didn't put it in there because it was flat and this is an overhead.

MS. BEE: These are just hospital based.

MR. PETTENGILL: All of these are hospital based.

DR. WAKEFIELD: So my question is --

MR. PETTENGILL: I didn't include it because it was flat.

MR. SMITH: Julian, back to Jack's question for a minute, I would think in order to answer it you would have

to know something about a bed-to-population ratio, rather than simply facilities with the service. Otherwise, it doesn't tell us very much about the availability of the service if we don't have some metric that allows us to match up potential demand with potential provision. Simply facilities doesn't get to that.

MR. PETTENGILL: I wasn't thinking about this in the context of what it says about access to various kinds of services. I was thinking about it more as an indicator of how rural providers respond when they have different circumstances.

MR. SMITH: But in a very small market, one swing bed is very different from three. I'm saying that the presence of a swing bed capacity doesn't tell you very much unless you match it up with something about population.

MR. PETTENGILL: I don't know whether you could do that in a way that would be meaningful.

MR. SMITH: I was just wondering if not doing means that this data is very meaningful.

MR. PETTENGILL: I think all it tells you is that

hospitals that are located in more remote rural areas are more likely to have swing beds than --

MR. SMITH: At least one.

MR. PETTENGILL: Yes, that's true. I suppose if we had time to -- many of these maps and tables raise many more questions than they answer, that's clear. And if we had the opportunity to pursue some of this stuff, I think we could maybe find some much more interesting things. But under the circumstances, we don't have the time to do it at this moment.

We could do some follow-up work, perhaps next year, and I'm not promising to do that, but we could bring it up at the retreat.

I think it's time to go on to the use rate part of this, which is a reprise, that Dan will do.

DR. ZABINSKI: Thank you. As part of this chapter we're going to include a comparison of rural and urban beneficiaries' use of care. At the March meeting we presented preliminary results from that analysis. In the meantime, we have modified it, adding post-acute care to

beneficiaries' use and addressing commissioner's comments.

Before discussing the results from that analysis, we think it's important to mention that one should be really careful about not reading too much into use rates when you're interpreting them because they are, in some cases, rather crude indicators of potential problems.

For example, one may be tempted to conclude that lower use by rural beneficiaries indicates an access problem for them. But this would overlook other possibilities such as differences in practice patterns or beneficiaries' propensity to seek care.

Also, I think we should always be aware that use rate differences do not always indicate a similar difference in impact on health outcomes. For example, two beneficiaries using the same amount of care could have very different health outcomes because their quality of care, their need for care, and the mix of their services could be very different.

The first thing we looked at in our analysis are national average differences in urban and rural

beneficiaries' use rates. We grouped the beneficiaries into six categories using the same five rural categories that Julian had on his diagrams and added an urban group.

On this diagram we have the ruralness of beneficiaries' groups along the horizontal axis. On the very left column we have the metropolitan or urban group. As you move to the right, you get to more progressively rural groups.

The vertical bars indicate average use for each group.

DR. NEWHOUSE: Are those dollars?

DR. WILENSKY: It would be nice to have something on the axis to give us some idea.

DR. ZABINSKI: It's sort of an index of use. What we're measuring basically is like the amount of care that the beneficiaries would have as measured if Medicare used national payment rates, basically.

DR. NEWHOUSE: I think you need to put in the units, when you do this for real -- when it goes on Broadway.

DR. ROWE: Explain to me, what's striking here is the lack of a difference. This is one of the themes from the last meeting, that many of the places we expected to see a difference, the differences more modest or non-existent. But it's not clear to me that the way you did this you couldn't have shown a difference if you wanted to.

So what exactly is the amount of care? Is this per person?

DR. ZABINSKI: This is per beneficiary, right.

DR. ROWE: Medicare beneficiary.

DR. ZABINSKI: Per Medicare beneficiary.

DR. ROWE: And this is some unit of hospitalization, doctor visits, home care visits, some mixture?

DR. ZABINSKI: Typically what we did was this. Let's use physician care as an example. We would take the relative value units for each physician unit and multiply it by the national adjustment factor. And then we did the same sort of thing for hospital inpatient using DRGs, hospital outpatient care using value units, and so forth.

DR. NEWHOUSE: It's units of service weighted by the same prices for everybody.

DR. ROWE: That's great. Would it be fair that if we assumed that the degree of illness or sickness or care need is the same across the country -- I'm sure that's not the case, but let's just stipulate that -- that in fact, therefore, the health care needs of people across the country are being rather equally -- I'm not saying adequately, they may only be getting 70 percent of what they need -- but equally addressed, irrespective of whether they are in an urban or rural setting? Is that what this says?

DR. ZABINSKI: I would say that use is about the same in rural and urban settings. But as far as health care needs, addressing that point Jack, as you see here we have for each ruralness category you have two sets of bars. The wider one on the left indicates a raw use rate. The one on the right indicates adjusted for health status differences between groups.

But adjusting for health status doesn't really change the qualitative analysis here of use rates really

don't look much different.

DR. WILENSKY: They don't look much different, even unadjusted.

DR. NEWHOUSE: And the adjustment is actually imperfect, so if anything it looks like the rural use, if anything, may be greater because the urban group is sicker because of the missing HMO group. I think the sameness or the lack of a big difference is the important point.

MS. ROSENBLATT: I have a question on this now that I understand the mathematics of it. If it's weighted by dollars, the hospital DRG dollars are going to be really dominant in the total. And therefore, if there's a very slight difference in the hospital usage, that's going to drive the similarity --

DR. REISCHAUER: Makes rural use look a lot greater.

MS. BEE: As we work through the analysis, we've also included some detail on the composition of services within that bar. Indeed, that bar is the total of inpatient, outpatient, physician, rural health clinic, and

all post-acute settings. And we'll break that out to see how the composition of that varies.

DR. ROWE: This really gets to, just for the record because we discussed this earlier, the celebratory nature of at least some of what these data suggest, and that is that assuming that we started at a place where there was greater disadvantage in rural, with respect to access to care, this would appear to address the question of access and say that, at this point at least, there are not very substantial systematic deficiencies by category. There may be individuals or individual markets, et cetera. But at least by category of ruralness, with respect to the amount of care that's being delivered.

DR. WILENSKY: Use, not access. Access is somewhat more complicated. But at least in terms of observed use, it looks very comparable, given the measures that are shown here.

DR. REISCHAUER: Just to elaborate on Alice's point, to come to a conclusion totally different from Jack's, folks in rural areas don't see physicians as often,

don't get the same kind of preventive care, end up in the hospital more, and then we celebrate it. This is a hypothesis.

DR. ZABINSKI: There is one difference and it's actually coming up in the later slide. Urban beneficiaries do use quite a bit more physician services and rural beneficiaries do have a fair amount more hospital inpatient care.

DR. WILENSKY: Again, I think this is a useful way to look at an aggregate cut at what is going on, and then you need to back up and talk about what's lying underneath it. But I do think it's important, in the places where we see more comparable use than we might have expected, to point that out. And in the places where we see differential use, as in terms of physician care or home care or the mix between skilled nursing facility and home care, that we make those comments, as well.

DR. ZABINSKI: Before we move on from the slide, there's one thing I'd like to point out, though. This diagram includes only fee-for-service beneficiaries. It

excludes Medicare+Choice. In particular metropolitan areas that's an important group. It encompasses about 21 percent of that population. So if you included Medicare+Choice in this, the relationship might change some because they're typically healthier than that.

But the data for those people don't exist, in terms of claims data, so we really can't include them.

DR. WILENSKY: I assume in the final chapter, that would be included on the chart? You want to have, if somebody picks up this chart, there's a footnote at the bottom that says excludes HMO enrollees.

DR. NEWHOUSE: That's a really important caveat.

DR. ZABINSKI: Yes.

DR. ROWE: But what you're saying, Dan, if I understand, and I think this is important, is that that might be the case with respect to the light bar, but the darker bar --

DR. NEWHOUSE: No.

DR. WILENSKY: No.

DR. ROWE: --which corrects for health status,

since the Medicare+Choice people are healthier, there would be a correction there vis-a-vis their health status that might compensate for the change.

DR. NEWHOUSE: Not enough.

DR. ZABINSKI: It's an imperfect correction, though.

DR. ROWE: What would it show, do you think, if you then put in the Medicare+Choice population?

DR. NEWHOUSE: Drop the metropolitan.

DR. WILENSKY: Drop the metropolitan.

DR. ROWE: Exactly. It would make the rural look like it was getting more, even though it may be different categories of care.

How much substitution is there, to get to Professor Reischauer's excellent point? Is there some change in the finances so that it's not all just dollars, so that if somebody doesn't get to the doctor and therefore they wind up in the hospital and that is obviously more expensive to it's more use, is there any substitution metric here?

DR. NEWHOUSE: Right. That's what we need to say.

DR. ZABINSKI: No.

MR. PETTENGILL: If they show up, if they go to the hospital and they're more seriously ill so they end up in a more expensive DRG, that would be included. But if they went and they were more seriously ill but ended up in the same DRG, coronary bypass say, but they were more likely to have complications and result in outlier payments, that wouldn't be here.

DR. ROWE: But if they don't get a flu shot because they don't get to the doctor, and they get influenza and they get in the hospital, it looks like they used more health care.

MR. PETTENGILL: That's right.

DR. ROWE: And they had the same health status going in. That's the point.

DR. WILENSKY: They do use more health care.

DR. ROWE: If they don't get influenza, because you have to catch it from someone, then they're apparently living in a place where there's no one else.

[Laughter.]

MS. ROSENBLATT: How did you risk adjust it down?

DR. ZABINSKI: I used the risk factors from the HGC, the hierarchical condition category model.

MS. ROSENBLATT: You're using inpatient and outpatient?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: And it's a single weighted DRG, that dollar value? You're not doing this DRG by DRG in hospitals?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: You are doing it DRG by DRG.

DR. ZABINSKI: Somebody has an inpatient stay, we take the DRG weight and multiply it by a national adjustment factor.

MS. ROSENBLATT: And the unadjusted, if there are more people going to the more severe DRGs in the metropolitan area, that would cause the metropolitan weight to be higher?

DR. ZABINSKI: It would raise the metropolitan use.

We also looked at this on a region by region basis, as well. When we've looked at the beneficiaries in the regions, we continue to find small urban and rural differences in the adjusted use rates within regions. However, we did find that overall use is fairly different between regions.

In this diagram, once again we separate the beneficiaries into four regions. Once again, the light bars indicate the unadjusted use rate, and the darker bars indicate adjusted for health status.

I'd like you to focus on the West and the South, that is the second set of bars and the final set of bars on the right. The South is higher and the West is lower. For example, the adjusted use rate in the South is about 15 percent higher than what it is in the West.

DR. WAKEFIELD: This is just rural?

DR. ZABINSKI: No. This is everybody together.

DR. WAKEFIELD: Everyone in that region.

DR. ZABINSKI: Yes, this is urban and rural together, everybody in the region. So the overall use rate in the South is higher than what it is in the West.

As we already discussed, though, one important discrepancy that we have here between urban and rural is that the mix of service is quite different. As I said, urban beneficiaries use more physician care and, to a lesser extent, more post-acute care services. Conversely, rural beneficiaries use more hospital inpatient and hospital outpatient services.

DR. ROWE: Can you give us some quantitative measure of what you mean by more?

DR. ZABINSKI: Physician, in the neighborhood of about 15 percent more in urban areas.

DR. ROWE: 15, 1-5?

DR. ZABINSKI: 15. Post-acute care not quite so. It was about 8 or 9 percent. Hospital inpatient care, 7 or 8 percent higher in rural areas. Hospital outpatient, it's more extreme, probably in the neighborhood of 10 to 12 percent, I'd say.

DR. ROWE: But if you add -- so hospital outpatient use is less or more?

DR. ZABINSKI: It's more in rural areas.

DR. ROWE: Because if you add that together with the physician visits in the community, since there might be fewer physicians --

DR. NEWHOUSE: And the rural clinics.

DR. ROWE: What do you wind up with?

DR. ZABINSKI: Pretty flat.

We also try to address some concerns that the commissioners raised at the March meeting. First, we examine variation in use to see if rural counties are more likely to have either very high use rates or very low use rates. For each county we compared per capita use to the national average. And we found that rural beneficiaries are both much more likely to live in counties with very high use rates, as well as very low use rates.

DR. NEWHOUSE: Dan, is this on a year?

DR. ZABINSKI: Yes.

DR. NEWHOUSE: I think you need to make a

technical correction here. Since this is going to be interpreted as some kind of steady state behavior, I think you need to correct for number of lives. Just on random variation, rural will bounce around more than urban.

DR. ZABINSKI: We tried to do that. For example, what we did -- okay, we calculated a standard deviation of the use rates across counties and then we calculated an 80 percent competence interval for each county's use rates using that standard deviation. But if a county had fewer than 30 people, we used the adjustment factor from the student T distribution that applies to the size of the --

DR. NEWHOUSE: You can actually make a fix right on the number of people. We can talk about it afterwards.

DR. ROWE: Can we go back to a second to the prior slide. I just want to make sure -- it says urban use more physician services and you just told me that if you add up the physicians in the community and the physicians in the outpatient and the clinics it's the same.

DR. ZABINSKI: No, the physician services are just physician services. It doesn't matter where they are. They

all go. If physician care takes place in an outpatient unit, it goes into the physician category, but just those services that the physician supplied.

DR. NEWHOUSE: How about the rural health clinic?

DR. ZABINSKI: The rural health clinic, we use it as a separate category in the total, but when you add the rural health clinic to the physician care it closes the gap.

DR. ROWE: So we should get the data before we make this final statement here?

DR. ZABINSKI: No, I think the statement is correct. All physician services are put into the physician category. It doesn't matter whether they're in a physician office, some sort of inpatient care.

DR. NEWHOUSE: But the equivalent of the outpatient department facility fee is in the physician component for when you go to the office, and it's not in it when you go to the outpatient department. I think that's Jack's point.

DR. ROWE: That's my point.

DR. NEWHOUSE: I think Jack wants basically

outpatient services, as opposed to physician services.

DR. ROWE: Yes, because the patient is seeing a doctor, the fact that there's a global fee rather than a physician and a facility fee and it doesn't show up as a physician service. And it is, we're talking about doctors seeing patients. And this, for the non-cognoscenti, that might potentially be misleading.

MS. RAPHAEL: I just want to clarify the post-acute because I think we are getting contrary information here. For home health care, I think I remember there were more visits per beneficiary in the rural areas. So that would mean that in that center, at least, the post-acute, the rural use is higher.

I don't know what it is on the SNF side and we were asking questions before that how best to measure it.

MS. BEE: The observed use is both the use per beneficiary and the volume per user. And so one of the aspects that makes home health flat is that though we have fewer users per beneficiary, rural beneficiaries use more services. And so that tends to flatten out the total home

health use between urban and rural.

So when we talk about use, it's the conjunction of those two influences.

DR. ROWE: Is that consistent with this statement, that urban use more post-acute services?

MS. BEE: We have a picture for you.

DR. WILENSKY: I think the answer is, yes, this slide is correct but it's because of in the rural areas you have a lower likelihood of use, and once you use you have a high use rate.

MS. BEE: Right.

DR. WAKEFIELD: Maybe this is drawing a distinction that you're not so interested in, but isn't it also the case that it's a higher number of visits, but the amount of therapies that are provided to rural beneficiaries is markedly lower than those therapies provided to their urban beneficiary counterparts? That's an important distinction, I think.

MS. BEE: Right. That's part of what our wizardry is trying to get at. By trying to value these all at a

constant dollar, we've managed to capture that therapy is a little bit more complex and a little bit more intense than an aide or a skilled nursing care. So hopefully by standardizing that, we've captured that.

DR. ROWE: What's the specialty hospital?

MS. BEE: In this slide, it's long-term care and rehab. We've also measured psych but we've included that as an acute service, rather than a post-acute.

DR. WILENSKY: Again, don't forget that we have a special chapter that looks at home care so that we go into more detail, specifically about the difference in therapy use. And that what we're trying to do here is present an overall view of what is going on.

DR. WAKEFIELD: Right. Just my only question is, back to that national use rates, and the fact that that reflects a lot of stuff going on in that one chart, and how it could be interpreted.

DR. WILENSKY: If you have a single summary chart, that's the nature of what you're doing.

DR. WAKEFIELD: It needs to be described in the

narrative.

DR. ZABINSKI: Also when we look at variation in use, we've tried to separate the high use counties from the low use counties. In this diagram, the dark green marks, although they're not as distinct as I would have liked, but the darker green marks indicate high use counties. The lighter green marks indicate low use counties.

Not surprising, you get a pretty high concentration of high use in Louisiana, but also Mississippi and Texas. The low use counties are somewhat spread throughout the Great Plains and the Rocky Mountain states in the West.

DR. STOWERS: Is this use per beneficiary?

DR. ZABINSKI: Yes.

DR. STOWERS: Because that would be very important because several of these are very remote counties that may have 200, 300 people in them. And yet they're a high use county.

MR. PETTENGILL: The intent here was not to say, this is a problematic county, it's definitely high use off

the scale or low use off the scale. It's that these are places that if you were looking -- it was to try to get to Mary's point from last time, where she was saying can't we see something about the diversity, how much variation there is.

These are the extremes. Now they may or may not be problems. You'd have to look further to know that.

DR. NEWHOUSE: But I don't think we want to take account of just random variation that bounces around from year to year. Maybe that was what Mary wanted, but I think that's misleading. If you had one big case in a county with 200 beneficiaries, so what?

DR. WAKEFIELD: No, I wasn't interested in random variation. It was trying to tease out -- what I think the staff has done actually the best job they could in the time that they had, and that is to try and break down the information as discretely as possible to try to not move back from all rural and label all rural with one diagnosis, and instead to really try to tease out to get a better understanding of where are the problem areas and then

address policy solutions to those particular areas. That was the driver.

DR. WILENSKY: Julian, I think the attention that you'll face, and Dan also, in what you've got in terms of your discussion, is this balance between trying to aggregate so that people can get an overall message, which I think is important and you've done, and indicate the but underlying an aggregate similarity are important differences that build to that aggregate. And you're going to have to look to the later chapters to decide whether those differences reflect different ways that services are going to be provided for a whole series of reasons -- some geographic, some historical, some economic -- and whether they're appropriate or inappropriate differences.

But it's going to be this tension of you want to pull together. That is the point of this chapter, to kind of get an overview of what's going on, but to indicate thereafter to the extent that there are important differences like the overall use rate, but differences in terms of what's made up, and just reference this discussion

later. So that you provide early on a reference point to later parts of the volume, and also remind people even early on that what looks similar has important component differences which they may or may not decide ought to have a policy associated with it.

I don't want you to have the takeaway message to back off from these aggregate statements. It's very important we try to look at what it looks like when you take the different measures that are talked about later in the volume and put them all together, what does it look like? And the same with the various adjustments.

It's the best way to try to get an overall view, and then we can go through the differences.

MR. PETTENGILL: We were just seeking to find the balance ourselves between the overall conclusion and not be telling people that it's the same everywhere. It isn't the same.

DR. WILENSKY: The other issue that you're going to need to try to balance in the discussion is the area in which Medicare is the appropriate policy instrument in the

area when there is a problem that is viewed or there's an issue that's viewed as problematic, that there may be areas of policy that are not appropriate to Medicare, even though they're appropriate to intervention.

Having that theme so that you can lay it out first and then, as we go through the later chapters, either that you can point to or that later chapters can point back to. So that either in the summary statements to the individual chapter or in the overview chapter or in the executive summary, someone is going to need to pull this together. Here are the areas where we think Medicare is the appropriate instrument by refining how we calculate cost differences or make other changes in payment. And then there may be other areas that are appropriate for intervention but they're not Medicare issues or they're not issues that Medicare is likely to impact in a meaningful way. And therefore, to the extent that they're regarded as important policy issues, we'll have to look for another tool.

I think this chapter, it's not the executive

summary, which will have an important role to fill, but you ought to be leading the way with what will come and hopefully have some references back in the later chapters to what went on here.

MR. PETTENGILL: We'll try to do that.

MR. SMITH: Along the same lines, Julian, it seems to me important to be clear where we can that revealing a difference doesn't reveal a problem, and some of the discussion that we tried to have about the effect of substitution for outpatient visits for physician visits, that it reveals a difference but it may not reveal a problem. We're not sure.

There will be a tendency to consume this report and focus on differences and to find differences as problems and where we're not sure that differences explain problems it seems to me important to point that out.

DR. REISCHAUER: On the same token, a lack of difference doesn't mean a lack of problem.

MR. SMITH: Right.

DR. LOOP: I was just taking some notes. I think

this is a good introductory chapter. The objective, if we can just talk about fundamentals for a minute, the objective here of all of these chapters is to try to help the rural beneficiary that truly needs help. And as a secondary objective, help the rural hospitals that are truly in need. It seems to me that's what we're trying to do here.

I think the goal is made a lot more difficult by the raw definition of rural hospitals. You've got 40 percent of the hospitals in the United States are classified as rural and yet only 20 percent of the population is considered rural. And so the problems of the really rural hospitals, at the end of the spectrum of ruralness and also as defined by some of your risk factors, is diluted by the data from the more urban rural hospitals.

I think this is also complicated by the fact that there's this Brownian movement of reclassification of hospitals.

Now I may be in an area where politics are going to be so strong that you'll never be able to influence policy, but I think the best thing that this commission

could do is try to redefine ruralness and make the definition of rural hospitals more explicit in the areas that are truly in need.

MR. PETTENGILL: That's pretty ambitious.

DR. WILENSKY: I think the point is well taken. To the extent we can at least raise the issue at this point, some of which is done in the UIC discussion and other discussions earlier, it would be very helpful. Again, as we proceed, when we do the hospital payment chapter through some of the other chapters, to try to raise this more explicitly, that the definitions have a highly political tinge or tone to them is something we're not going to be able to deal with. But I think to the point that we think there are important differences that suggest differential policy responses, we certainly ought to say that.

And I don't know how much you feel like you can inform this issue more than what's already in here, but I think it's a good point.

DR. LOOP: The definition, the way it is now. may prevent us from getting to the root of the problem.

MR. PETTENGILL: I don't know that it does. My sense is we're classifying as rural here hospitals that are actually physically located in a non-metropolitan county. In other words, we're not counting somebody as urban if they were reclassified to an urban area for the purpose of the wage index. So that's not an issue.

I think what the UIC code classification does for us basically is it sorts out the hospitals that tend to be larger, serving a larger population, and counties that area adjacent. Or even counties that are not, where they're in a town that's greater than 10,000.

That distinction, based on town size, I think is probably the one you want to make, compared to the hospitals serving more remote rural areas where the population is really small.

We can't do that perfectly, but I think we can sort it out enough to make it clear to people that these facilities are different and the conditions they face are different and the policy solutions may well have to be different.

MR. HACKBARTH: The fact that you have a higher proportion of hospitals being labeled rural, as opposed to percentage of the population being labeled rural, isn't that the byproduct of rural hospitals being smaller?

DR. WILENSKY: Yes.

VOICE: It's beds we should be counting.

MR. HACKBARTH: So to me, Floyd, that doesn't necessarily signify that we've got some not really rural hospitals classified as rural. It's just an artifact of the size of the hospitals.

DR. WILENSKY: But the general point is worth making, that sometimes what we classify is done for political reasons rather than other reasons. But to the extent that you've not included those in your discussions is helpful.

Any other comments?

MR. DeBUSK: I'm here in Section D, when we get into improving payments for inpatient hospital care in rural areas, then you run into a whole new classification.

DR. WILENSKY: Why don't we wait with that. We

will be spending almost two hours on that section this afternoon.

MR. DeBUSK: But then you put all that in with this and then the confusion gets even greater.

MR. SMITH: You've made the point several times that size is more important than adjacency. And you added three and five together. I wondered why you left seven out?

MS. BEE: Because someone in UIC seven could have a city right up to the MSA limit. So conceivably some cities within a seven UIC could be quite large. so we found that seven acted like adjacent counties with large cities more than it acted like either --

MR. SMITH: like isolated counties.

MS. BEE: -- with small cities.

DR. WILENSKY: Pete, did you want to raise something with regard to this chapter, as opposed to the chapter that's coming? We'll have a very long discussion on the payments.

MR. DeBUSK: No, I understand what you're trying to say. I think the game begins when we get to that section

about what's the reality of trying to classify all this stuff.

DR. WILENSKY: Okay, thank you. Commissioners who have individual comments to suggest to Julian on this chapter, please contact him and give him your comments on your written chapter drafts. ***[Next agenda topic begins.]***

Mary? We know you're here without your co-authors, one of whom is imminently waiting to hatch, we understand.

DR. MAZANEC: It's very lonely at this table today.

We have significantly revised the chapter on quality of care to reflect the Commission's comments at the March meeting. We tried to refocus the chapter to emphasize the needs of the beneficiary.

Medicare's primary goal is to ensure that its beneficiaries have access to medically necessary care of high quality. Recent evidence suggests that the provision of necessary ambulatory care is roughly comparable between rural and urban beneficiaries.